Society of Critical Care Medicine

TESTIMONY OF JOHN H. HOYT, MD, FCCM ON BEHALF OF THE SOCIETY OF CRITICAL CARE MEDICINE
BEFORE THE HOUSE PUBLIC WORKS AND TRANSPORTATION COMMITTEE
SUBCOMMITTEE ON PUBLIC BUILDINGS AND GROUNDS
TESTIMONY IN SUPPORT OF H.R. 881,
BANNING SMOKING IN FEDERAL AND CONGRESSIONAL BUILDINGS

April 22, 1993

Mr. Chairman and Members of the Subcommittee, I am John Hoyt, MD, FCCM, Chairman of the Critical Care Medicine Department and Medical Director of the Medical/Surgical Intensive Care Unit (ICU) at St. Francis General Hospital in Pittsburgh, Pennsylvania. St. Francis General Hospital is a 750-bed, full-service facility that has provided care to patients in Pittsburgh for 125 years. I am also a clinical professor of anesthesiology and critical care at the University of Pittsburgh, part of the largest fellowship training program of critical care physicians in the world.

I am a board-certified critical care medicine physician. My medical practice focuses on the care of individuals who suffer from immediate life-threatening illness and injury. My patients develop lung, brain and heart failure that is usually a result of trauma, extensive surgery, overwhelming infection, heart attack, stroke and poisoning that occurs from tobacco smoke.

My testimony today is presented as Treasurer of the Society of Critical Care Medicine, an organization comprised of more than 7,500 physicians, nurses and allied health care practitioners who are committed to the care of the approximately 4 to 6 million Americans who become critically ill or injured each year. Members of the Society are, unfortunately, all too well aware of the significant health care consequences of prolonged smoking or exposure to second-hand smoke that cost this country significant health care resources each year. Smoking kills nearly 400,000 Americans annually, including 115,000 from coronary artery disease; in general, smokers double their risk of heart disease compared to non-smokers; while those smokers between the ages of 45 and 64 years of age are three times more likely than non-smokers to suffer from heart disease. Another 27,000 Americans die from stroke, 136,000 from cancer and 50,000 from other related illnesses. A survey published by the Society of Critical Care Medicine reported that on any given day, 14.6 percent of all ICU admissions are diagnosed with respiratory insufficiency or failure. Every year, $22 billion are spent on the medical costs related to illnesses caused by the addiction to tobacco. Medicare and Medicaid spend $4.2 billion annually for the care of patients with tobacco-related illnesses.

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Recently, I experienced one of the busiest nights in the ICU I can recall in my 17-year career as a critical care intensivist. Of the eight patients I admitted to the ICU that night, six were admitted with smoking-related illnesses and needed the support of a ventilator to breathe. Their disease, Chronic Obstructive Pulmonary Disease (COPD), literally obstructs the workings of the lung. The lung consists of a delicate architecture of tubes and sacs, that allow gas exchange and oxygen delivery. Smoking leads to damage of these tubes and sacs and obstructs the flow of oxygen to the lung. COPD causes inadequate function of the lung, shortness of breath, limited exercise ability, the need for support from mechanical ventilation and finally death from respiratory failure. The process is long and debilitating; many COPD patients suffer for as long as five years before dying of this disease. Their care is expensive; the cost for a patient to receive support from a ventilator is eight times more than average hospital care. According to the Centers for Disease Control, sixty thousand Americans die each year of Chronic Obstructive Pulmonary Disease.

How do tobacco-related costs add up in the ICU? My colleague, Dr. Timothy Buchman, Co-Director of the Surgical ICU at Johns Hopkins Hospital in Baltimore, recently published a study in the journal *Chest*, of admissions to his unit which showed that tobacco, alcohol and illegal drug-related illnesses and injuries accounted for 28 percent of the admissions and 29 percent of the medical costs during a 15-week period. The 435 patients admitted to this particular ICU generated $3,014,953 in costs in a unit with a per night cost of $3,000 per bed. The 59 patients with tobacco-related illnesses alone accounted for $481,648 in costs, or approximately $8,000 each. Tobacco-related cases that involved cancer and respiratory diseases accounted for 14 percent of the admissions and 16 percent of the costs. All but one of the 59 cases were related to cigarette smoking; one case was related to cigar smoking.

The physical and societal ills associated with smoking affect not only adults, but our children as well. A 1991 report from the Department of Health and Human Services reported that half of all eighth graders and nearly two-thirds of all tenth graders have tried cigarettes. Infants are also adversely affected; 20 to 30 percent of low birth weight babies, up to 14 percent of preterm deliveries and approximately 10 percent of all infant deaths are attributable to cigarette smoking during pregnancy.

The life-threatening effect of passive smoking has been well documented. The recent EPA report, "Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders" clearly stated the dangers of breathing second-hand smoke. When inhaled, environmental tobacco smoke is a human carcinogen that can be directly blamed for the lung cancer deaths of 3,000 non-smokers each year in the U.S. In children, second-hand smoke clearly increases the risk of lower respiratory tract infections, including bronchitis and pneumonia, resulting in the hospitalization of 7,500 to 15,000 infants and children each year. This carcinogen also increases the prevalence of middle ear disease and the frequency and

severity of symptoms in asthmatic children. According to the EPA, the condition of 200,000 to 1 million asthmatic children is worsened by exposure to second-hand smoke. The Society of Critical Care Medicine agrees with former EPA Administrator William K. Reilly's statement that environmental tobacco smoke may present the most important environmental health risk facing Americans today.

In this era of historic health care reform, where quality of care, access to care and cost of care are such intensely debated issues, these results - - which are due to ***preventable*** illness - - are entirely unacceptable. The "common courtesy" approach to eliminating passive smoking that is advocated by the tobacco industry has not worked. Policymakers, health care providers and patient advocates, all must ensure that the health of Americans is not further endangered by tobacco smoke. We must ensure that scarce and expensive health care resources are allocated in the most efficient manner possible. Too many other *unpredictable and unpreventable* illnesses and injuries require our attention, including overwhelming infection, traumatic injury, multi organ system failure and others. Improving the health of all Americans, by eliminating smoking and the diseases it causes, will prolong life and release the precious human, physical and financial resources needed to care for other patients.

The Society of Critical Care Medicine supports H.R. 881, which would establish a complete ban on smoking in all federal and Congressional buildings. Serious health problems caused by smoking have been well documented over a number of years. We believe it is time for Congress to take a stand and take the lead on this important issue by banning smoking in all private offices and public areas of federal and Congressional buildings.

Mr. Chairman, members of the Subcommittee, thank you for the opportunity to present the Society's views on this very important issue. We look forward to working with Congress and Members of the Subcommittee to eliminate this life-endangering threat to the lives of all Americans, adults and children. I will be happy to answer any questions you or the Subcommittee Members may have at this time.